VOLUME 4:

Quality Management
and
Grievance and Appeals

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QUALITY MANAGEMENT

GRIEVANCE AND APPEALS

Function and Structure
NARBHA has developed a quality management (QM) program that systematically monitors and evaluates the quality and effectiveness of its internal systems, as well as ensuring the delivery of high quality services by its contracted provider network.

NARBHA's QM Department has responsibility to ensure compliance with required ADHS/DBHS performance standards, as well as responsibility for coordination and support of performance improvement activities, planning, utilization management, risk management, and grievance and appeals.

Oversight of Quality Management Activities
NARBHA's Leadership Council, led by the CEO and comprised of Department Directors and other key management staff, has responsibility for oversight of QM activities. Leadership Council is directly involved with planning activities, ensuring that there is input from staff, the Board of Directors, key providers, behavioral health recipients (members), family members, and other key stakeholders on planning activities, including development of the Strategic Plan. In addition, Leadership Council receives weekly reports from other committees involved in QM activities, and is specifically responsible for determining any sanctions imposed on the provider network based on failure to meet performance measures.

The NARBHA Leadership Council has designated the Provider Performance Committee (PPC) as the quality committee for NARBHA. The PPC is responsible for reviewing all provider monitoring data, contract performance indicator data, utilization management (UM) data, and provider network sufficiency information. The NARBHA Medical Director provides oversight for quality areas. Monitoring results that indicate a need for improvement are forwarded to the Provider Improvement Committee (PIC) for development of improvement plans. The Performance Improvement Manager, who is responsible for managing all provider monitoring, facilitates both PPC and PIC.

Quality Management Functions
NARBHA is actively involved in the following QM and quality review activities in order to improve quality of care.

- Planning: developing the NARBHA Strategic Plan and quarterly goal monitoring; developing the annual QM/UM Plan and related work plan; developing the annual Performance Improvement (PI) Plan
- Provider Monitoring/Performance Standards: tracking, trending, and reporting provider compliance with contract performance measures, utilization measures, and provider monitoring activities; monitoring Medical Care Evaluation studies; recommending improvement to providers and the PIC
- Clinical Record Review: conducting and analyzing annual Case File Review and specialized clinical record reviews with NARBHA's provider network; aggregating ADHS/DBHS Independent Case Review and analyzing results by provider agency; conducting and analyzing quarterly Utilization Management Record review; recommending needed improvement activities to the PIC
- Performance Improvement: developing internal performance improvement indicators in conjunction with NARBHA Leadership Council; tracking quarterly progress and recommending needed improvement to Leadership Council; reviewing subcontracted providers' PI plans and evaluating annual PI Plan
- Utilization Management: conducting specialized studies and analyses for the organization, such as diagnosis study, penetration analysis, covered services (under- and over-utilization); producing quarterly ADHS/DBHS Inpatient File and quarterly Showing Report; producing UM data and reports to support UM decisions for the organization
- Member Satisfaction/Provider Satisfaction: conducting and analyzing bi-annual Member Satisfaction Survey (in conjunction with ADHS/DBHS); conducting annual NARBHA Provider Satisfaction survey
- Member Services: responding to, tracking, and trending member services calls for information; responding to member and provider complaints; conducting Eligibility and Enrollment record review at Service Area Agencies and Tribal Area Agencies (SAAs/TAAs) to determine compliance with provider eligibility screening and enrollment requirements
- Member Rights: training NARBHA and provider staff on member rights and responsibilities, ensuring that contracted providers implement member rights notification and requirements
- Grievance and Appeals Function: conducting grievance investigations regarding persons with a serious mental illness (SMI), reviewing member appeals, and reviewing provider claims disputes in accordance with ADHS/DBHS and Balanced Budget Act requirements; conducting quarterly provider record review for presence and completeness of grievance and appeal notices; conducting improvement activities with providers not meeting standards

- Risk Management – Critical Incidents, Sentinel Events: notifying ADHS/DBHS within one day of significant critical incidents, as required; aggregating critical incidents by provider and forwarding to ADHS/DBHS and Northern Arizona Human Rights Committee; conducting investigations for selected critical incidents and reviewing provider root cause analysis reports for reported sentinel events; presenting information such as critical incident analysis to NARBHA Risk Management Committee.
- Credentialing and Re-Credentialing Process: credentialing, re-credentialing, and privileging of licensed independent practitioners and organization providers; oversight of credentialing processes delegated to SAAs

Staff Qualifications and Number of Personnel

The NARBHA QM function consists of 11 staff. Four positions report to the Director of QM, and each of them in turn supervises staff. Additional NARBHA staff outside the QM Department are involved in QM activities such as committee participation, credentialing/privileging, and risk management, but are not listed on this table. Staff charged with primary QM functions at NARBHA, and their responsibilities, qualifications, and FTEs are depicted below.

Title	Responsibilities	Qualifications	FTEs
Director of Quality Management	Department Director for all functions, QM Plan, incident reporting, rights, ethics, quality indicators, member of Leadership Council, Provider Performance, Plan and Design, Risk Management and Privileging Committees	Masters degree, with 26 years experience	.75
Performance Improvement Manager	Strategic Plan, Performance Improvement Plan, management of provider monitoring, supervision of member services, member of Leadership Council, Chair of Provider Performance Committee	Masters degree, with 10 years experience	1.0
Grievance and Appeals Administrator	Administrative oversight for grievance and appeals, informal conference mediation	Certified Paralegal - by July 2005	.75
Clinical Review Supervisor	Oversight of all clinical record review functions, supervision of clinical record reviewer, review of member appeals; individual case reviews	Masters degree, with 15 years clinical experience. Licensed by AZ Board of Behavioral Health Examiners	.50
Clinical Record Reviewer	Clinical record reviewer, mortality reporting, Seclusion and Restraint reporting	Masters degree, with 4 years clinical experience. Licensed by AZ Board of Behavioral Health Examiners	.50
Provider Monitoring Coordinator	Monitoring of SAA/TAA performance measures, MCE studies, Member and Provider Satisfaction Surveys	Bachelors degree, with 8 years experience	1.0
Member Services Representatives	Member services representatives, complaints	1 Bachelors degree; 1 Associates degree, 3 years combined experience	2.0
Grievance/Appeal and Eligibility Specialist	Investigator for member grievances, provider claims dispute, liaison to Human Rights Committee	Bachelors degree, 2 years experience	1.0
Utilization Management Data Coordinator	Data reports and analysis	Currently vacant; requires Bachelors degree and 3 years experience	.25
Data Analysts (2)	Utilization Management data reporting and analysis	1 Masters degree; 1 Associates degree, 15 years combined experience	1.0

Improvement Model

For the past several years, NARBHA has utilized the Shewart/Deming *Plan-Do-Check-Act* (PDCA) cycle as its systematic method for improving specific processes. This cycle ensures that NARBHA uses data to drive decisions for improvement, develops and implements comprehensive improvement plans, evaluates new process changes, and follows up on actions taken to ensure that achieved levels of performance are maintained.

System to Ensure Implementation and Effectiveness of Improvement Activities

NARBHA implemented a new committee structure in November 2003 to more readily support system-wide Performance Improvement activities.

Leadership Council

The Leadership Council, comprised of the NARBHA CEO, the Department Directors, and other key management staff, functions as the oversight body for Performance Improvement activities for both the internal and provider systems.

- Internal systems: On an annual basis, Leadership Council selects for monitoring those internal processes that are the most high risk, high volume, high cost, high impact and/or problem-prone in the organization to ensure that the internal organization is functioning as effectively as possible. Some examples of internal process monitors for 2004 include NARBHA reaching a 99% reconciliation between the DBHS and NARBHA member databases during each quarterly review; implementing requests for computer data reports, creation of databases, and changes to existing programs within at least six months; and implementing at least 85% of the developed improvement plans as written. Leadership Council reviews the monitoring information gathered on the selected internal processes on a quarterly basis to determine if improvement opportunities exist. If opportunities do exist, staff members create a plan for improvement based on the PDCA cycle. One of the potential components of a plan aimed at improving an internal process is the creation of a Performance Improvement Team. A Performance Improvement Team at NARBHA is a group of individuals from different departments of the organization brought together to solve an issue using a systematic, structured problem-solving process. Leadership Council routinely reviews the status of all internal improvement plans, including Performance Improvement Teams, to ensure that they are progressing as planned and achieving the desired outcomes.

- Provider systems: The Leadership Council reviews and discusses committee reports from the Provider Performance Committee (PPC), Provider Improvement Committee (PIC), and Plan and Design Committee (PADCO). In addition, the Leadership Council approves all recommended provider financial sanctions that might be part of an improvement plan. The role of each committee in performance improvement follows.

Provider Performance Committee (PPC)

The PPC, comprised of all of the Department Directors, is responsible for reviewing provider performance on key processes. The PPC prioritizes areas for improvement based on a set of criteria including: how issues relate to organizational priorities; whether they are high risk, high volume, and/or have a trend of non-compliance; and whether resources are available to address the issues at that time. Once issues have been prioritized for improvement, the PPC determines where to forward them to initiate improvement activities. If processes requiring improvement need modification to achieve the desired level of performance, the PPC refers them to the PIC to develop improvement plans. If they require major design or redesign efforts to reach performance expectations, the PPC forwards the issues to the PADCO so that the process may be completely redesigned. The PPC approves all improvement plans developed by the PIC to ensure that resources are available to implement the plan as developed. In addition, the PPC reviews a status update report on the current improvement plans at each meeting and assists the PIC in working through any barriers.

Provider Improvement Committee (PIC)

The PIC, comprised of at least two line staff members from each department, is responsible for developing and implementing improvement plans for items identified by the PPC. These improvement plans include what is going to be done, who will be involved, when the steps will be carried out, and how the level of performance will be evaluated to determine if improvement was achieved. The PIC tracks and documents the status of each step using a standardized spreadsheet to ensure that they are carried out as developed. As mentioned above, the PIC forwards status update reports to the PPC for review. If the plans do not achieve expected results, the PIC modifies the plan and identifies other activities that could be implemented to increase the level of performance.

The Performance Improvement Manger, who is responsible for managing all provider monitoring, facilitates both the PPC and the PIC.

Plan and Design Committee (PADCO)

The PADCO, comprised of the Department Directors, is responsible for designing all-new performance improvement processes and redesigning processes that require complete overhauls to achieve the desired level of performance. After receiving referrals from the PPC, the PADCO creates design or redesign teams that are responsible for developing, implementing, and evaluating process designs/redesigns. The teams consist of individuals involved in the processes that are to be designed/redesigned. Documentation of the process designs/redesigns include an outline of the new process flow, a description of how the new design will be evaluated to ensure it is working as expected, and an outline of the implementation plan. The assigned design/redesign teams report the status of their designs/redesigns to PADCO on a regular basis as identified in the design/redesign plan. If the expectations of the designs/redesigns are not achieved, the teams redesign the process to more effectively meet expectations.

Examples of Success

The implementation of NARBHA's improvement model and related activities has resulted in the following positive outcomes:

- Accessibility standard; referral to first available appointment: resulted in all Service Area Agencies/Tribal Area Agencies meeting the 85% performance standard

- Engagement Activities occur for individuals at risk for decompensation and/or inappropriate disenrollment from the system; outreach occurs after service refusal: resulted in NARBHA exceeding the 80% standard (with 83% for adults and 100% for children)

- Assessments are sufficiently comprehensive for the development of functional treatment recommendations: resulted in NARBHA exceeding the 85% standard (with 96.6% for adults and 91.8% for children)

- Staff actively engage the individuals, families, and other agencies in the treatment planning process: resulted in NARBHA exceeding the 85% standard (with 93.6% for adults and 98.6% for children)

- There is evidence in medical record charts of functional improvement as a result of treatment: resulted in NARBHA exceeding the 80% standard (with 90.3% for adults and 90.4% for children)

- Follow-up actions to address medication side effects or adverse reactions are documented: resulted in NARBHA exceeding the 85% standard (with 100% for adults and 100% for children)

NARBHA's quality management system involves behavioral health recipients (members), family members, provider agencies, NARBHA staff, and stakeholders through a variety of mechanisms in order to gain information, feedback, and insight into needs, expectations, services, and needed improvements throughout the NARBHA system. These mechanisms include: participation in committees and meetings; satisfaction surveys; analysis of grievances, appeals, and complaints; and other feedback.

NARBHA Staff Involvement: NARBHA staff are involved in system-wide quality management through their participation in NARBHA's Leadership Council, Provider Performance Committee (PPC), Plan and Design Committee, and Provider Improvement Committee. The missions and compositions of these committees are detailed in Volume 4.a.2.

Consumer Satisfaction Survey: NARBHA conducts a bi-annual consumer satisfaction survey in coordination with the ADHS/DBHS Consumer Satisfaction Survey process. Enrolled members from each Service Area Agency/Tribal Area Agency (SAA/TAA) are surveyed. The survey domains include access to care, outcomes, quality/appropriateness of care, member and family participation in treatment planning, cultural sensitivity, and general satisfaction with services. The results of this survey are aggregated by Regional Behavioral Health Authority (RBHA), as well as statewide. NARBHA, in turn, aggregates the results by provider agency. The survey serves as a source of information regarding consumer and family member perceptions of the behavioral health system in Northern Arizona and identifies opportunities for improvement.

Trending of Grievances, Appeals, Complaints: **NARBHA produces a quarterly report of member complaints, grievances, and appeals. The data are aggregated by type of complaint, frequency of complaint, and provider agency. Reports are presented to the NARBHA Provider Performance Committee and Risk Management Committee (which includes representation from each SAA/TAA) for identification of trends and areas on which to focus improvement efforts. This information is a source of member input and an indicator of member dissatisfaction, and is used to identify needs in the region as well as gaps in the provider network.**

Provider Satisfaction Survey: NARBHA conducts an annual Provider Satisfaction Survey with each of the SAAs/TAAs. Questions are focused on provider perception of NARBHA departments and functions. The results of the survey, including scoring and comments, are reviewed by the NARBHA Leadership Council (the NARBHA CEO, Department Directors, and other key leaders) to identify any system-wide issues needing to be addressed, as well as areas regarding member perception of individual providers. NARBHA Department Directors also receive comments specific to their functions/areas to share with their staff. This process provides an added mechanism to obtain provider input into NARBHA processes.

Strategic Plan: NARBHA develops an annual Strategic Plan, which includes an annual review of the NARBHA Mission and Values statement, an internal and external analysis to identify major strategic issues for the coming year, and a selection and prioritization of goals and action plans for the coming year. Meetings are conducted with stakeholders and provider agencies to obtain input and feedback on the Strategic Plan and its direction and contents. NARBHA Leadership Council reviews and considers these comments for incorporation into the Plan.

Provider Network: NARBHA meets with providers on an ongoing basis through regularly scheduled meetings, soliciting input, and providing information and feedback. These meetings include the following.

- NARBHA Leadership Council meets with the SAA/TAA CEOs monthly
- NARBHA Medical Director meets with the provider medical practitioners monthly
- NARBHA Clinical Operations Director and staff meet with SAA/TAA adult and child staff monthly
- NARBHA Management Information Systems (MIS) Director meets with key SAA/TAA MIS staff monthly
- NARBHA Director of Finance meets with the fiscal staff from the providers monthly

Member, Family, Provider, and Stakeholder Input Mechanisms: In June 2004 NARBHA, as part of a strategic planning initiative, established the Family Leadership Committee, a core group of family leaders, behavioral health recipients, and community stakeholders who will help institute major change in the design, planning, and implementation of the behavioral health delivery system that provides services that are individual- and family-centered and culturally relevant. NARBHA uses this mechanism to further strengthen its capacity to improve behavioral health for consumers, improve organizational infrastructure, focus strategic planning and technical assistance efforts, increase operational effectiveness, and heighten public awareness of and mobilize community support for behavioral health. By

moving in this direction, NARBHA upholds the ADHS/DBHS System Principles, Arizona Children's Vision and Principles, and the Principles for Persons with a Serious Mental Illness. NARBHA is firmly committed to the active solicitation of input from members, family, providers, and stakeholders with the objective of guiding, shaping, and modifying the behavioral health delivery system to achieve true integration that meets the behavioral health service needs of individuals and families. Examples of this input follow:

Groups to Obtain Input from Recipients, Family Members, and Community Stakeholders

Group	Composition	Purpose	Frequency
Adult and Child Meeting Population-specific: Seriously Mentally Ill; Substance Abuse and General Mental Health; Childrens Services	NARBHA, providers	Discuss issues of concern relative to their respective constituencies such as treatment practice guidelines, clinical criteria, and the uses of new and existing clinical technologies.	Every Other Month
Cultural Competency Committee	NARBHA, providers, families	Involvement and input in developing and implementing programs and services that respond to the needs of the culturally diverse community.	Monthly
Wellness Committee	NARBHA, providers, families	Involvement and input in developing and implementing programs and services that provide primary, secondary, and tertiary prevention.	Quarterly
Office for Children with Special Health Care Needs (OCSHCN) Community Alliances	NARBHA, families, consumers, stakeholders	These parent-led organizations can give feedback directly to their NARBHA committee representatives or directly to the NARBHA Barriers Resolution Subcommittee.	Monthly
ADES/Division of Developmental Disabilities EOM	NARBHA, DDD, families	Improve coordination and discuss recommendations for system change and improvement between NARBHA and DDD.	Every Other Month
ADES/Child Protective Services EOM	NARBHA, CPS, families	Improve coordination and discuss recommendations for system change and improvement between NARBHA and CPS.	Every Other Month
Strategic Plan Stakeholder Group	NARBHA, families, consumers, state agencies, advocacy groups, community stakeholders	Involvement and input in developing NARBHA's strategic plan.	Annually
Prevention Coordinators Meeting	NARBHA, community stakeholders	Discuss issues of concern relative to prevention. Involvement and input in developing and implementing system-wide prevention efficacy.	Every Other Month
Health Plan Coordinators Meeting	NARBHA, AHCCCS behavioral health coordinators and medical directors	Improve coordination and systemic care between NARBHA, the Arizona Health Care Cost Containment System Health Plans, and Primary Care Physicians.	Every Other Month
NARBHA Board of Directors	NARBHA, Stakeholders, consumers, families	Provide information and feedback on the development and delivery of behavioral health services. Set direction for NARBHA governance.	Monthly

Communication of Stakeholder Input into Quality Management System: NARBHA has a centralized point of communication and coordination of stakeholder input into the quality management system. As a monthly standing PPC agenda item, the committee members report relevant consumer, family, provider, and stakeholder input and information that has been discussed at the variety of meetings with these stakeholders during the past month. In this way, NARBHA leadership is aware of and has the opportunity to address stakeholder input into the NARBHA and provider system. This information is also conveyed regularly to NARBHA's Leadership Council from the PPC.

NARBHA has been accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Managed Behavioral Health Care Organization since March 2000. Re-surveyed in April 2003, NARBHA continues to be fully accredited with no Type I recommendations. NARBHA's current accreditation continues until 2006.

NARBHA's seven Service Area Agencies (SAAs), which are community-based, comprehensive behavioral health care providers and key network contractors, also are JCAHO-accredited as Behavioral Health Providers. Accreditation provides assurance that a wide variety of quality standards are met, and that standardized expectations of performance and quality between NARBHA and its major provider agencies are in place. Accreditation offers NARBHA and its SAAs the opportunity to incorporate national health care standards into operations within the context of the ADHS/DBHS contract.

There has historically not been a conflict between accreditation requirements and the ADHS/DBHS contract. Potential conflicts between JCAHO accreditation requirements and ADHS/DBHS contract requirements are not expected, due to widespread similarity between current ADHS/DBHS contract requirements, standards, monitoring, and improvement processes and JCAHO requirements. NARBHA believes that JCAHO accreditation assists NARBHA and its SAAs in complying with ADHS/DBHS requirements because of the JCAHO focus on continually improving the safety and quality of behavioral health services.

In the event of a conflict between JCAHO and ADHS/DBHS requirements, NARBHA will fully adhere to all ADHS/DBHS and AHCCCS contract requirements. In determining its provider network, NARBHA adds providers based on the needs of members; these providers do not have to be accredited in order to become part of NARBHA's network.

In situations where NARBHA is required to add a provider to its network in an expeditious manner, single case agreements are used to meet member needs quickly. If ongoing provider network capacity becomes an issue and NARBHA intends to work with that single-case provider on a longer-term basis as a fee-for-service provider, the complete credentialing and contracting process described in Volume 2.a is initiated; there is no requirement that fee-for-service providers be accredited by a national organization. Single case agreements can continue to be used to meet member needs as the comprehensive credentialing and contracting process is completed.

NARBHA's Quality Management (QM) Department is the primary source for generation and coordination of quality management information within NARBHA, with the provider network and other community stakeholders, and with ADHS/DBHS. Reports, plans, monitoring results, and other information are generated and communicated both within and outside NARBHA and utilized for decision-making and information sharing. Methods of communication include dissemination at NARBHA internal and provider committees, electronic means (NARBHA's website, e-mail), written communications that are distributed in a variety of methods, on-site visits, and other provider monitoring and technical assistance activities.

The QM Department also serves as the primary point of interface with ADHS/DBHS to ensure that state-level quality management information flows into NARBHA for incorporation into all QM plans and initiatives. NARBHA staff actively participate in a variety of monthly Regional Behavioral Health Authority (RBHA) and DBHS committees and meetings, including RBHA Directors, Medical Directors, Quality Management Directors, CFOs, and Information Systems Managers, as well as specific ADHS/DBHS quality improvement projects.

Committee Structure

NARBHA's committee structure serves as the primary forum for communicating and disseminating QM information. *Leadership Council* is the management hub of NARBHA's committee structure and coordinates all communications, including QM information. The Leadership Council, chaired by the CEO, meets weekly and is comprised of Department Directors and other senior management staff. Leadership Council approves the NARBHA QM/Utilization Management (UM) Plan and oversees activities of both NARBHA's internal committees and its external stakeholder and provider committees.

Internal NARBHA Committees

The *Provider Performance Committee (PPC)* serves as the primary QM committee within NARBHA. The PPC meets twice monthly and includes each Department Director, the Medical Director, and NARBHA Legal Counsel. All QM, provider performance, and UM data are reviewed by this committee, which identifies improvement opportunities. The NARBHA Medical Director provides oversight for quality areas.

The PPC refers provider improvement areas to the *Performance Improvement Committee (PIC)*, which functions as the improvement committee for NARBHA. The PIC meets twice monthly and consists of at least two line staff members from each NARBHA department. The PIC is responsible for development, implementation, and tracking of improvement activities for NARBHA providers.

The Performance Improvement Manager, who is responsible for managing all provider monitoring, facilitates both PPC and PIC.

Provider and Stakeholder Committees

NARBHA has an extensive structure of standing committees, which involves all levels of Service Area Agency and Tribal Area Agency (SAA/TAA) staff along with other community stakeholders. SAAs/TAAs serve as NARBHA's primary providers by offering a comprehensive array of services in nine sub-regions located throughout NARBHA's geographic service area. The provider and stakeholder committees serve as the major vehicle to communicate and disseminate information from NARBHA to the provider network and to behavioral health recipients (members), family members, and the Arizona Department of Economic Security/Child Protective Services and Rehabilitation Services Administration. NARBHA also uses these forums to collect feedback from the provider network and stakeholders. Committees consist of monthly SAA/TAA Director (CEO) meetings, as well as function-specific committees, such as Adult and Child Team, MIS, Finance, Quality Management/Member Representative, Medical Practitioners, Risk Management, and Health Plan Coordination. The committees meet regularly and review plans, data reports, and results of quality and provider monitoring. Committees are also the primary setting for NARBHA to communicate policy changes, provide training, and share information about new initiatives. Meetings are available to participants via NARBHA's videoconferencing network to increase availability and accessibility across the large geographic service area.

Provider Site Visits and Technical Assistance

NARBHA conducts annual site visits for each of the SAAs. This provides a vehicle to communicate with each provider regarding its compliance with contractual and performance standards, an opportunity for development of mutually agreed-upon performance improvement activities, and an opportunity for NARBHA staff to visit provider sites and give

feedback and input into provider planning processes. Quarterly follow-up visits are then conducted to review progress toward the meeting of mutually agreed-upon performance goals.

NARBHA staff also communicate with the provider network through a variety of technical assistance opportunities, such as consultation on specific complaints, appeals, or grievances, or methods to improve the accuracy or validity of electronically submitted enrollment data. These informal communication opportunities, along with structured training events, provide additional vehicles for NARBHA staff to communicate with providers regarding application of QM principles and standards.

Written Communication

Written communications, such as the AHDS/DBHS/NARBHA provider manual, policies and procedures, plans, clinical record review results, and provider monitoring reports, are distributed to NARBHA committees, the Board of Directors, provider agencies, stakeholders, and ADHS/DBHS. Written communication is utilized by committees, internal NARBHA staff, provider agencies, and ADHS/DBHS to make decisions about provider and NARBHA performance. Written communications are also sent by mail, e-mail, or fax.

Electronic Communication

NARBHA utilizes several means of electronic communication to provide widespread and timely methods of communicating quality management data and information to provider agencies, ADHS/DBHS, and other stakeholders.

NARBHA Website

NARBHA's corporate website, www.narbha.com, is an Internet site available to the public at large. The website includes general information such as provider agencies, a provider agency map, upcoming meetings, the Member Handbook, a member services description, the ADHS/DBHS/NARBHA Provider Manual, the NARBHA organizational chart, and training calendars and materials.

NARBHA is currently developing an Intranet/Extranet website that will allow specific groups of users to have access privileges to see information relevant to their specific organization or role in the NARBHA system. Outside stakeholders, SAAs/TAAs, NARBHA staff, and other identified groups within the NARBHA system will be assigned special permissions to access only the information that is necessary or relevant to them. For example, NARBHA department members can share files and SAAs can check the status of claims. The Intranet/Extranet will also allow NARBHA to disseminate information immediately and consistently to every appropriate group.

E-mail

NARBHA utilizes secure e-mail on a daily basis to communicate in a timely, efficient, and collaborative manner with its internal staff and SAAs through its network of private, point-to-point telecommunications lines. NARBHA also uses external e-mail to communicate with its TAAs and ADHS/DBHS. These communications are not secure; however, NARBHA has purchased encryption hardware to facilitate seamless, secure e-mail communications outside of its own private network. The types of information frequently communicated via e-mail include: policy clarifications; meeting information; new program initiatives; memoranda regarding any changes, modifications, or updates received from the Arizona Health Care Cost Containment System (AHCCCS) or ADHS; QM reports; or notification to providers that information is posted on the website. E-mail affords timely communication along with a record of receipt to internal and SAA staff, based upon the e-mail system's capacity to document both receipt and opening of e-mail messages.

NARBHA collects and maintains a wide variety of member, provider, and performance data sets. These raw data sets are in turn manipulated and transformed into organized informational reports, which serve as the basis for indicating areas in need of improvement. Quality improvement tools such as charting of performance over time and statistical analysis methodologies are used to further review and analyze this information in order to identify performance trends, substandard provider performance relative to established performance standards, and/or statistical outliers based on probability theory. The information is then presented to NARBHA committees for review and identification of areas needing improvement.

Collection Methods and Types of Data Collected

Data are collected using several methods throughout the NARBHA system.

- Electronic Data Submission
  NARBHA uses the CMHC/Management Information Systems (MIS) system as its primary business application. The CMHC/MIS system is the single point of entry for NARBHA's provider network to handle member enrollment and eligibility, demographic data, authorization, claims expenditure, adjudication, and claims payments. Data obtained from CMHC/MIS include claims/encounters from all network providers as well as claims from the pharmacy benefits manager. CMHC/MIS data sets facilitate further analysis of and breakout of information to identify areas in need of improvement and to facilitate productive improvement efforts.

- Clinical Record Review
  Through multiple record review processes, NARBHA Quality Management staff collect data on-site at contracted provider agencies to evaluate appropriate documentation of clinical care and to evaluate the application of ADHS/DBHS and NARBHA standards to clinical practice. Results are summarized and analyzed for presentation to NARBHA committees and the provider agencies. The providers use these results to improve both clinical documentation and practice.

- Manual Data Collection
  Data are collected by NARBHA or by provider agencies, and are submitted either in an electronic or paper format to NARBHA. This includes data from access-to-care logs; critical incident reports; sentinel events; grievances, appeals, and member complaints; inpatient and residential utilization management; Medical Care Evaluation (MCE) studies; and accessibility. This information is used to monitor utilization, performance measures, and risk management processes. Data are aggregated and supplied to the provider agencies, comparing providers to each other and trending provider performance over time.

- Satisfaction Survey Data
  NARBHA conducts satisfaction surveys of members, provider agencies, and stakeholders. Survey information is collected manually, and then either scanned into a database or entered into an electronic database. Analysis is presented by provider agency, and reports are generated and presented to NARBHA's committees. If improvement opportunities are identified, NARBHA works collaboratively with the provider agencies to improve performance.

Data Analysis

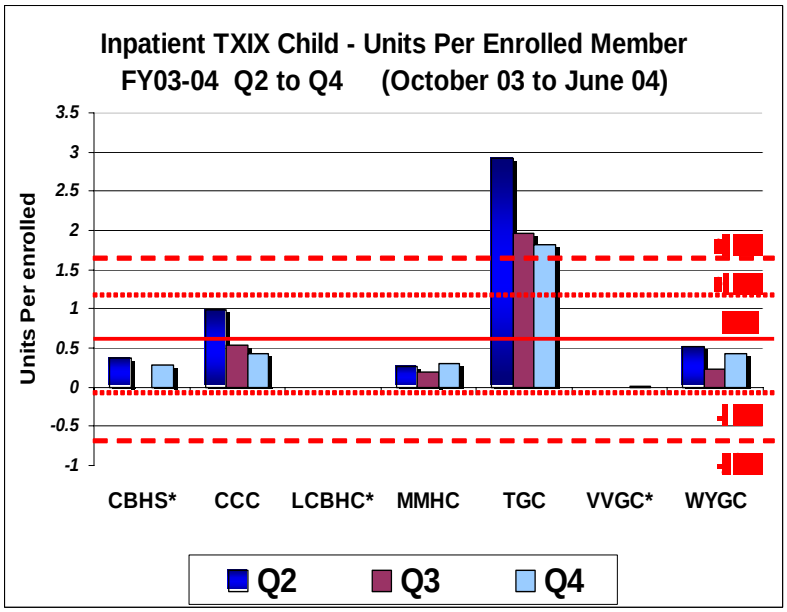
NARBHA utilizes a number of methods in the analysis of various data sets to facilitate comparison to established performance targets. These performance expectations are set by ADHS/DBHS contract, Arizona Health Care Cost Containment System (AHCCCS) requirements, internal NARBHA standards based upon best practice, and/or statistical methods.

- **Minimum Performance Standards, Goals, and Benchmarks**
  Each performance indicator in the ADHS/DBHS contract, including Independent Case Review measures, has defined minimum performance standards, performance goals, and performance benchmarks. NARBHA has adopted these expectations for each of the performance measures, and compares provider performance to each of these standards in order to define areas that are not meeting expectations. NARBHA has defined additional performance indicators and has set minimum performance standards, goals, and benchmarks for each indicator. SAA/TAA performance for each of the NARBHA performance indicators is reviewed quarterly by NARBHA committees. Areas needing improvement are communicated to individual provider agencies, and improvement plans developed and implemented.

- Statistical Methods

Statistical techniques are employed in the analysis of selected data and informational sets to facilitate understanding and target improvement efforts related to an established process and/or performance measure. Basic examples of statistical methodologies used include measures of central tendency (mean, median, mode), disparity in performance (variance, standard deviation), and performance anomalies/outliers based on probability theory (e.g., probability of this event occurring is less than 5 out of 100 trials). Quality management tools, such as Pareto charts and histograms are then used to graphically display this information and to highlight statistical findings. One example of how these statistical methodologies and charting tools are synthesized is the analysis of inpatient and residential service utilization. An example of information used by NARBHA to make management decisions is depicted below for Title XIX children receiving inpatient services.

As noted in this chart of Title XIX Children Inpatient Utilization, one provider agency (TGC) was initially identified during the 2nd quarter of the year as an outlier based on performance in excess of two standard deviations above the mathematical mean (application of probability theory). This information was presented at the SAA Directors/CEOs Meeting and discussed with the provider agency in the context of units of service and associated financial implications. Subsequent performance reflects a trend of performance improvement. Additional efforts are being made to successfully manage provider performance.



*LCBHC and VVGC had no inpatient utilization for these particular quarters; CBHS had no inpatient utilization for Q3.

Committee Review and Improvement Process

Results of utilization and other quality management performance data are referred to NARBHA's Provider Performance Committee for discussion and action. Data are presented that compare provider performance against NARBHA and ADHS/DBHS expectations, and that compare provider performance over time. If the information indicates a trend or pattern that consistently fails to meet expectations over time, improvement in performance may be required of the providers. Corrective action may be requested of provider agencies, or there may be a referral to the Performance Improvement Committee for development and implementation of an improvement plan.

NARBHA receives and generates a vast amount of quality and utilization management data. Ensuring that the data are complete, timely, and accurate is necessary in order to make correct quality improvement and utilization management decisions. This is done through several different methods, which are dependent upon the type of data, how the data are generated, how NARBHA monitors the information, and what methods are in place to identify problems and ensure that identified problems are addressed and corrected.

NARBHA requirements for the submission of quality and utilization management data are defined and communicated to the provider network through policy and/or contract requirements. NARBHA has a stable provider network that is familiar with the standards for complete, timely, and accurate quality and utilization data submissions. Technical assistance is provided to the Service Area Agencies/Tribal Area Agencies (SAAs/TAAs) on a regular basis as needed, and detailed training is offered to providers as new initiatives and requirements are implemented.

NARBHA utilizes a variety of sources of quality and utilization management data in order to evaluate provider performance on a current and real-time basis. This includes utilization management data for prior authorization of inpatient and residential treatment, claims and encounter data for utilization management analysis, and quality management data from clinical record reviews and other sources.

Utilization Management Data

NARBHA delegates prior and continued authorization and denial of care to the SAAs/TAAs, which are the nine comprehensive providers in NARBHA's geographic service area (GSA). The delegation of certain utilization management functions ensures that care decisions are made by persons who are familiar with the member, are timely, and are administratively efficient. NARBHA requires that the following services be prior authorized, except in emergency situations.

- Inpatient hospital, including sub-acute services (per ADHS/DBHS policy)
- Level I Residential Treatment Services for persons under the age of 21 (per ADHS/DBHS policy)
- Level II Residential Treatment Services (Therapeutic Group Home) for persons under the age of 21 (NARBHA policy with formal approval from ADHS/DBHS)

NARBHA requires that SAAs/TAAs make decisions in accordance with ADHS/DBHS and NARBHA admission and continued-stay authorization criteria. Utilization data for inpatient and residential services requiring authorization are submitted to NARBHA directly by SAAs/TAAs on a weekly basis in order to ensure timely and accurate tracking of actual admission and discharge dates. The SAA/TAA data are verified for accuracy through a manual or via telephone visit with the agency that is actually providing the inpatient or residential services. The two sets of data, from the authorizing SAA/TAA and from the treating provider, are compared and any discrepancies are reconciled and corrected. This verification process ensures valid and reliable utilization information is obtained on a real-time basis, and facilitates timely decision-making for utilization management purposes. One example of the use of this information is the production and reporting of the quarterly Inpatient File and quarterly Showing Report to ADHS/DBHS.

NARBHA analyzes pharmacy claims data to measure utilization patterns and performance against evidence-based practices. The pharmacy claims data are provided by NARBHA's subcontracted national pharmacy benefits manager, CaremarkPCS, which submits these data to NARBHA 12 times per year. Applications written by NARBHA's Management Information System (MIS) staff review these files for internal consistency and to balance and validate detail-level data to trailer summary totals. When these internal processes are complete, control reports are prepared for the NARBHA Finance Department to review and balance to the previously submitted CaremarkPCS invoices. If there is no discrepancy between the reports, the NARBHA Finance Department authorizes NARBHA MIS to proceed with the next step. If there is a discrepancy between the control reports and CaremarkPCS invoices, the NARBHA MIS and/or Finance Departments contact CaremarkPCS to resolve the issue.

For services other than inpatient, residential, or pharmacy, NARBHA has developed a Covered Service Mapping Model during the past year, which analyzes utilization of all covered services provided in the GSA in a comprehensive and logical manner. Data used for this analysis come from claims and encounter data submitted by NARBHA providers. More than 95% of claims/encounters are submitted to NARBHA electronically and more than 90% of claims/encounters are received from SAAs. Both NARBHA and the SAAs use the same management information system software, which serves to improve the accuracy of the data through consistent database formats for client eligibility, enrollment, and demographic elements. In addition to the data validation processes built into the information system software, the

utilization management mapping process includes the identification of potential coding-related issues which would potentially skew report findings.

Quality Management Data

Clinical record reviews, conducted by NARBHA's Quality Management staff, are NARBHA's primary source of quality management data. Using record reviews as the collection method for quality management data allows NARBHA to obtain timely data from the original source document, thereby ensuring the accuracy of the data. NARBHA's record review process also allows providers to have input into the results from the review process, thus allowing any reviewer errors to be identified and corrected at the time of the review. Provider participation in this manner further improves the accuracy of the resulting data.

The following types of clinical record review are used to collect quality management data. Except where specifically noted, the reviews are conducted at all SAAs/TAAs.

- Case file review (CFR): The NARBHA CFR process is designed to mirror the ADHS/DBHS Independent Case Review (ICR) process and is scheduled six months following the state's ICR, which results in SAA/TAA clinical record review results at six-month intervals.

- Utilization management record reviews: On a quarterly basis, NARBHA staff review a sample of records from inpatient and residential stays to determine whether ADHS/DBHS, NARBHA, and federal Certificate of Need/Recertification of Need criteria and requirements are being applied correctly. These reviews also include provision of required grievance and appeal forms associated with any denial, reduction, suspension, or termination of services.

- Eligibility/enrollment review: Annual reviews are conducted on a sample of new enrollments to ensure that required screening for Title XIX and Title XXI eligibility has occurred. These reviews also identify any members where fund source has not been accurately reflected in the NARBHA management information system.

- Special record reviews: As a part of implementing new initiatives or when a priority area has been identified, NARBHA conducts targeted, ad-hoc record reviews to determine the efficacy of training and how well an initiative is being applied in actual member care. For example, clinical record reviews were conducted in early 2004 to measure compliance with the requirements associated with the implementation of new ADHS/DBHS assessment forms and processes.

- Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) record reviews: On an annual basis, record reviews are conducted to measure SAA compliance with JCAHO standards that are not covered in any of the record reviews described elsewhere. These reviews include areas such as environmental, patient rights, and pain management.

- Fee-for-service (FFS) record reviews: Sampled FFS records are reviewed annually according to JCAHO standards, such as assessment, care, continuum, and performance improvement.

An inter-rater reliability process is employed by NARBHA clinical record reviewers to ensure reliability of review information.

Data Timeliness

For quality data other than that collected from record reviews, NARBHA maintains a monthly tracking system that measures whether each provider's required submissions have been received and the timeliness of the submission. This includes items such as critical incidents, access-to-care logs, and Level 1 sub-acute utilization reports. Variances in the timeliness of submissions are noted and reported back to providers, and financial sanctions may be imposed according to NARBHA policy.

Provider monitoring, and subsequent performance improvement, is taken very seriously by NARBHA and is viewed as one of its primary responsibilities. In light of that fact, NARBHA has established a focused process to ensure that these activities are conducted to improve care and meet contract requirements.

Identifying the Focus of Monitoring Activities

On an annual basis, the NARBHA Leadership Council (comprised of the NARBHA CEO, Department Directors, and other key management staff) selects a set of "key processes" to monitor. A process is determined to be "key" if the Leadership Council determines that satisfactory performance of that process is crucial to the success of the overall system. In identifying key processes for monitoring, the Leadership Council reviews information from the current NARBHA Strategic Plan, the ADHS/DBHS contract, the historical performance data, stakeholder input, internal staff input, and state and national trends and best practices.

The results of this selection process are compiled into a list of Provider Performance Measures for the current fiscal year. The measures are divided into functional area sections such as Leadership, Information Management, and Utilization Management. Other items that are identified include the source of the data, the frequency of review, the minimum performance standard, the performance goal, the performance benchmark, and the internal staff member responsible for the measure.

Collection of Monitoring Data/Information on Key Processes

The following items are examples of activities that generate monitoring data on identified key processes.

- Fiscal Year performance measures (includes items such as submission of contract deliverables, submission of clean claims, timely submission of enrollments/assessments, referral to first available appointment, and chemical dependency residential census)

- Utilization management record review (chart review that reviews items such as appropriateness of initial and continued stay for out-of-home services, appropriateness of Certificate Of Need/Recertification Of Need forms, and appropriateness of grievance/appeal notices)

- NARBHA case file review (chart review that reviews same questions as found in the ADHS/DBHS Independent Case Review)

- NARBHA Joint Commission of Accreditation for Health Organizations (JCAHO) Record Review (chart review that reviews for items required by JCAHO accreditation that are not already found in the NARBHA Case File Review)

- Fee-for-service (FFS) chart reviews (chart review of NARBHA's FFS providers to ensure that they are meeting contract requirements)

- Annual Provider Network Development and Management Plan/needs assessment review (review status of projects identified on the network development matrix to reduce identified gaps in the system)

- Office of Behavioral Health Licensure/JCAHO/other accreditation reviews (review final reports to determine how the NARBHA system is performing relative to licensure/accreditation standards)

- Complaint/complaint resolution/grievance/appeal tracking log (review of aggregate data to determine the categories and sources of issues)

- Consumer satisfaction surveys (review of survey results data to determine where members are or are not satisfied relative to the care they are receiving)

- Community feedback data (review of aggregate focus group discussion data to determine potential gaps in the system)

- Practitioner prescribing pattern data (polypharmacy) (review of aggregate medication data to determine trends in prescribing patterns)

- Provider agency site visits (annual site visits to review overall performance for the previous fiscal year on key performance measures and other critical issues)

- Medical care evaluation requests and final study results (review of requests and final results to identify if providers are using this information to improve care)

All of the raw data from the above activities are collected and converted to organized, useful information by staff trained in the use of various quality management tools such as histograms, run charts, control charts, selection grids, and Pareto diagrams. This process allows NARBHA to more readily identify trends, variance from expectations, and statistical outliers during the analysis phase described below.

Analysis of Monitoring Information

The information generated by the monitoring activities is forwarded to the NARBHA Provider Performance Committee (PPC), comprised of Department Directors and ad-hoc members as necessary, for review. The PPC reviews the information using a two-dimensional approach. The committee members review the level of performance on measures across all providers on a scheduled recurring basis throughout the year. This allows the members to determine how each of the providers is doing on a particular measure as compared to the other providers. In addition, the PPC devotes one meeting every quarter to the review of each provider's performance individually across all of the key processes reviewed during that period. This allows the committee members to determine how each provider is performing relative to all performance expectations.

Identification of Performance Improvement Opportunities

The PPC reviews providers' level of performance against the identified minimum standard, performance goal, and performance benchmark. It is expected that providers meet the minimum performance standard and continually strive to meet the performance goal and benchmark. Improvement opportunities are identified when providers are either not meeting the minimum performance standard or have a statistically significant drop in performance level. Prioritization of improvement opportunities for each provider occurs at the time of the quarterly overview. NARBHA staff conduct face-to-face meetings to review the findings with each provider, paying particular attention to the processes that have been identified as improvement opportunities.

Development and Implementation of Improvement Plans

The NARBHA Provider Improvement Committee (PIC), consisting of line staff members from every department, is responsible for coordinating the development and implementation of all improvement plans that relate to provider performance. Additional ad-hoc members from NARBHA and the provider network, who are responsible for the processes prioritized for improvement, are identified and subsequently requested to participate in PIC meetings in order to assist in the development and implementation activities. Improvement plans may include the use of corrective action requests and financial sanctions (approved by the NARBHA Leadership Council) as incentives for providers to improve their performance. The PIC documents and tracks the status of all ongoing improvement activities and reports any barriers to the PPC. The members of the PPC assist in the removal of those barriers to increase the likelihood of success.

The utilization management system for NARBHA and its provider network is designed to ensure that individual members seeking services receive care that consists of the most clinically appropriate services, at the right level of care, with the right provider, for the right amount of time, and at the right intensity. Services are designed to meet assessed and prioritized needs in ways that are planned, individualized, and evaluated, and to achieve the best clinical outcomes.

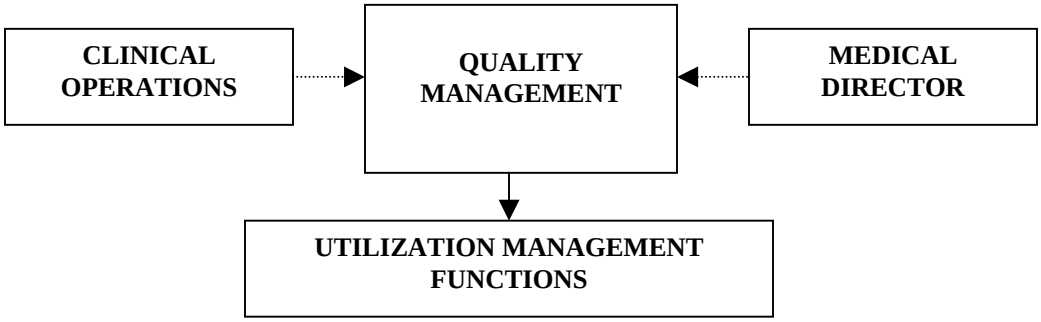
NARBHA's approach to utilization management is based upon the ongoing review of aggregate data in accordance with managed care principles to identify patterns of under- or over-utilization. This approach is data driven and results in a timely and ongoing evaluation process that contributes to administrative management decision-making. Data are also provided to the contracted provider network to assist them in identifying their specific utilization patterns and to provide them with information to manage individual cases.

Utilization Management Function and Structure

NARBHA is accountable for all utilization management functions throughout its geographic service area (GSA), but delegates selected functions, such as prior and continued authorization and denial of care to the Service Area Agencies and Tribal Area Agencies (SAAs/TAAs), which are the nine comprehensive providers in the GSA. The delegation of certain utilization management functions ensures that care decisions are made by persons who are familiar with the member, are timely, and are administratively efficient.

All staff performing delegated utilization management functions are employed by the SAAs/TAAs and are required to be physicians or behavioral health professionals who are appropriately credentialed to perform these activities.

The chart below illustrates the collaborative roles of NARBHA's Clinical Operations Department and Medical Director in supporting the Quality Management Department's utilization management functions.



The structure and responsibilities of staff positions participating in the UM function are described in the table below.

Position Title	Responsibilities	Qualifications	UM FTEs
Director of Quality Management	Develops annual Utilization Management (UM) Plan, oversees data collection of UM indicators, oversees clinical record review staff	Master's degree, with 26 years experience	.25
Director of Clinical Operations	Reviews clinical utilization data, oversees review of individual cases as needed	Master's degree, with 25 years experience. Licensed by AZ Board of Behavioral Health Examiners	.25
Medical Director	Develops and reviews medication reports, polypharmacy reporting, reviews individual cases as needed	Board Certified Psychiatrist, 15 years experience	.25
Utilization Management Data Coordinator	UM data reporting and analysis, supervises data analysts, develops Inpatient File, Showing Report, UM data reports	Currently vacant; requires Bachelor's degree and 3 years experience	.75

Position Title	Responsibilities	Qualifications	UM FTEs
Data Analysts (2)	Develop UM data reports, including UM indicators, over- and under-utilization of covered services	1 with Masters degree; 1 with Associates degree. 15 years combined experience	1.0
Clinical Review Supervisor	Conducts quarterly UM record review including retrospective review of admission and continued authorization of services, denials of care, and Certificate/ Recertification of Need, supervises clinical record reviewer	Masters degree, with 15 years clinical experience. Licensed by AZ Board of Behavioral Health Examiners	.50
Clinical Record Reviewer	Conducts quarterly UM record review including retrospective review of admission and continued authorization of services, denials of care, and Certificate/Recertification of Need	Master's degree, with 4 years clinical experience. Licensed by AZ Board of Behavioral Health Examiners	.50
Provider Performance Committee	Acts as the Quality Management Committee for NARBHA. Reviews all UM performance indicators, quarterly UM Record Review results	NARBHA Department Directors (includes 2 BHPs) NARBHA Medical Director NARBHA Legal Counsel	less than .25
Delegated to Service Area Agencies			
SAA Behavioral Health Professionals	Authorize initial and continued prior authorized services	Licensed by AZ Board of Behavioral Health Examiners	Provider staff
SAA MDs	Complete Certification/recertification of Need. MDs are the only professionals able to deny prior authorized services	Licensed Psychiatrist	Provider staff

Prior Authorization

"Prior Authorization" is a determination that approves the need for a covered service prior to the service being provided. Prior authorization efforts are focused on expensive and/or high-risk services. NARBHA maintains a prior authorization system that conforms to federal requirements for authorization and denial of inpatient services, and delegates this function to the Service Area Agencies (SAAs). The majority of behavioral health services do not require prior authorization, as they are not costly, high-risk services. These are authorized by the provider agencies in accordance with member benefits and clinical need. The system ensures that persons are treated in the most appropriate, least restrictive, most cost-effective manner that can safely and adequately treat the person's behavioral health disorder.

NARBHA requires that the following services be prior authorized, except in emergency situations:

- Inpatient hospital, including sub-acute services (per ADHS/DBHS policy)
- Level I Residential Treatment Services (Residential Treatment Center, or RTC) for persons under the age of 21 (per ADHS/DBHS policy)
- Level II Residential Treatment Services (Therapeutic Group Home, or TGH) for persons under the age of 21 (NARBHA policy with formal approval from ADHS/DBHS)

Continued stay authorizations and review

NARBHA requires that SAAs and Tribal Area Agencies (TAAs) make decisions in accordance with ADHS/DBHS and NARBHA admission and continued-stay authorization criteria. The SAA or TAA Treatment Team makes prior authorization decisions applying the required criteria. Any denials of care for prior authorized services must be made by a SAA or TAA physician. SAA or TAA authorization, continued stay, and denial decisions are retrospectively reviewed by NARBHA Clinical Record Reviewers on a quarterly basis to ensure that decisions are made and documented according to policy, and that the clinical record documentation supports the decision.

Medication prior authorizations and review

NARBHA requires prior authorization for the prescription situations listed below, although it never denies a request to prior authorize a medication; prescriber assurance that the medication is necessary is sufficient. All prior authorization

requests are processed within one business day and retrospectively reviewed by the NARBHA Medical Director for general trending.

- Brand-name medications on the NARBHA Medications Formulary when the generic form is available, per ADHS/DBHS
- Medication refills prior to 30 days when a 30-day supply was initially dispensed and/or when more than one quarter of the days remain on the previously filled prescription
- Prescriptions in excess of a 30-day supply or a 100-unit dose, with the exception of prescriptions for chronic illnesses, which are limited to a 100-day supply or 100-unit dose, whichever is more
- Specific unit dose strengths of medications on formulary: Zyprexa 2.5 mg, Risperdal 0.25 mg and 0.5 mg, and Abilify 5 mg

Utilization Management Monitoring

Utilization management functions delegated to SAAs are monitored and evaluated by NARBHA through clinical record reviews. The retrospective monitoring for appropriateness of prior authorization, continued authorization, and denial of care is conducted by the NARBHA clinical record review staff, who are also appropriately licensed and credentialed for this function.

The annual Performance Measures that SAAs/TAAs are required to meet include utilization management measures and indicators. There are 18 total indicators, which are monitored on a quarterly basis, with data aggregated by provider agency. Results are reviewed by the NARBHA Provider Performance Committee quarterly and utilized: 1) to determine how well individual providers are performing for each of the indicators; 2) as a method for NARBHA to manage utilization in an overarching way throughout the system; 3) to monitor over- and under-utilization of services in comparison with expected standards; and 4) to assist in identifying network sufficiency issues. If performance is not meeting NARBHA expectations, improvement may be initiated by either NARBHA or the provider network.

The utilization management measures are developed by NARBHA by considering questions that need to be addressed in order for the system to manage utilization. The questions considered are:

<u>Accessibility:</u>

- Are services uniformly delivered throughout the network?
  - Measures: 1) under- and over-utilization of covered services; and 2) children's out-of-home utilization
- Is there the capacity for all needed services?
  - Measures: 1) referral to availability of assessment within seven days; and 2) appointment availability within 30 days for medication
- Are eligible individuals being served?
  - Measure: Title XIX/Title XXI penetration rates
- Do individuals get services promptly?
  - Measures: 1) referral to emergency assessment within 24 hours; 2) routine services within 23 days of initial assessment; and 3) 24-hour response to Arizona Department of Economic Security/Child Protective Services child removals

<u>Appropriateness:</u>

- Do members get medically necessary covered services?
  - Measures: 1) members meeting authorization criteria for admission and continued stay for Level I and Level II facilities; 2) pregnant and/or parenting substance-abusing women receive services; 3) Correctional Officer/Offender Liaison (COOL) referrals receive services; and 4) follow-up services are provided after discharge from sub-acute facilities within seven and thirty days
- At the amount that is adequate?
  - Measures: 1) inpatient, RTC, and TGH length of stay; 2) interclass polypharmacy medications: members on three or fewer per month; 3) residential substance abuse treatment facility census; and 4) member utilization of Institutions for Mental Disease (IMD) facilities

<u>Cost Effective:</u>

- Are services being delivered in the most fiscally responsible manner?
  - Measures: 1) medication costs per population; and 2) cost per client

For each of the questions, utilization management performance indicators are defined as indicators of measurement. Standards are then established, data sources identified, and reporting of results defined. Proposed indicators are reviewed by the SAAs/TAAs prior to implementation in order to obtain input and consensus.

Monitoring of ADHS/DBHS Specific Contractual Requirements
NARBHA also monitors specific requirements of the ADHS/DBHS contract in the following areas:

- Certificate/Recertification of Need: SAA medical practitioners are required to complete a Certificate of Need (CON) or Recertification of Need (RON) for inpatient, sub-acute, and RTC services in accordance with federal, ADHS/DBHS, and NARBHA requirements. The completeness and accuracy of CON/RONs is monitored by NARBHA as part of the quarterly utilization management record review process. Improvement is required of providers who indicate a trend of substandard compliance. Improvement efforts have focused on technical assistance to the provider agencies, increased training, and requirements for weekly submission of CON forms to NARBHA. Most recently, SAAs are being financially sanctioned each quarter for those records that are incomplete or have errors. Performance continues to improve for this requirement.

- Institute for Mental Disease (IMD) Monitoring: In the NARBHA system, there are three facilities which fall under the IMD guidelines (16 or more beds): a hospital, a sub-acute facility, and a residential substance abuse treatment facility. The facilities and NARBHA have a tracking system in place that requires daily reporting to NARBHA on days utilized by individual Title XIX/Title XXI member. Requirements for these facilities are that individual Title XIX/Title XXI members cannot utilize more than 30 days per single stay or 60 days total annually in an IMD facility, or they lose their Title XIX/Title XXI eligibility while receiving services. This standard is aggressively tracked and reported monthly as a potential measure of over-utilization. NARBHA collaborates with the provider agencies to ensure that they are managing discharges appropriately for these members. Monitoring supports that discharges are appropriately managed for continuity of care.

Respite Services Utilization
NARBHA developed a system in fall 2004 to track and monitor utilization of respite services by enrolled members to ensure that not more than 720 hours of respite services are utilized by individual Title XIX/Title XXI members in any contract year.

Each contracted respite provider reports utilization of respite services by individual NARBHA-enrolled member to the NARBHA Quality Management Department on a weekly basis. NARBHA aggregates respite utilization by SAA and member and provides a tracking report to the SAA each month. SAAs are then able to take action to manage respite utilization for members identified as at risk for exceeding contractual limitations.

Reports are generated quarterly and reviewed by the Provider Performance Committee to track system-wide respite service utilization. In addition, the NARBHA claims system has a built-in edit that does not allow respite services to be reimbursed in excess of the maximum amount. This ensures that Title XIX reimbursement is not made beyond the service limitation.

Risk Management
NARBHA's risk management program is designed to protect the human and financial assets of the organization against the adverse effects of losses, effectively manage losses that may occur, and enhance the continuous improvement of member services in a safe health care environment.

The annual NARBHA Risk Management Plan identifies activities and practices that may cause loss to NARBHA members or staff, identifies training needs related to risk management activities, defines specific annual goals related to risk management, and identifies data and reporting to support identification of potential risk areas throughout the system.

The NARBHA Risk Management Committee, which consists of NARBHA and provider staff, meets quarterly and discusses significant events, high-risk areas, and progress toward meeting goals identified in the Risk Management Plan. The Committee reviews indicators of clinical risk, as well as risks in the areas of human resources, finance, and safety/environment of care. The committee may make recommendations to NARBHA's Leadership Council or Board of Directors regarding mitigation of potential risk.

By definition, management of covered services utilization encompasses the need to monitor for potential under- and over-utilization of service delivery. Prioritization and targeted areas of focus in monitoring under- and over-utilization are determined by a variety of factors including those with high strategic importance, such as ADHS/DBHS initiatives, Arizona System Principles, Arizona Children's System Vision and Principles, and Principles for Persons with a Serious Mental Illness (SMI). Other prioritization factors include follow-up on prior utilization performance findings, high cost/high volume services, evolving priority populations, cultural and/or age factors, new services being introduced, and systemic Service Area Agency/Tribal Area Agency (SAA/TAA) performance patterns identified by review of aggregate performance. All utilization findings are communicated to each of NARBHA's SAAs/TAAs, including a comparative review of all peer providers and overall NARBHA performance.

NARBHA uses a multi-tiered approach in monitoring for potential over- and under-utilization of services, including: 1) aggregate data; 2) tracking and trending out-of-home/out-of area utilization patterns/profiles and utilization management case file reviews; and 3) direct feedback received from enrolled members.

Aggregate Data Analysis

NARBHA's Covered Services Mapping Model

NARBHA has developed a covered services mapping model during the past year, which analyzes utilization of all covered services provided in NARBHA's geographic service area in a comprehensive and logical manner. The major elements of this model include:

- a systematic review of potential under- and over-utilization based on a comparative analysis of NARBHA's performance in relation to other Regional Behavioral Health Authorities (RBHAs) within the state
- an increasingly focused view of aggregate performance by covered service category, subcategory, and individual service code levels by SAA/TAA member service population and various fund types
- the identification of potential coding-related issues that would potentially skew report findings
- within the context of the ADHS/DBHS Covered Service Matrix, the integration of cost data and aggregate service delivery patterns and profiles to facilitate and promote targeted change efforts and realign SAA/TAA expenditures as needed

To facilitate a comparative review and promote informed decision-making, covered services data are reviewed quarterly by the NARBHA Provider Performance Committee (PPC) and analyzed by specific populations, subpopulations, funding, and other relevant permutations (e.g., all SMI vs. Title XIX SMI vs. Non-Title XIX SMI; Comprehensive Medical and Dental Program (CMDP) children vs. Non-CMDP Title XIX children) both at the SAA/TAA and NARBHA system-wide levels.

The initial ADHS/DBHS covered service reports have been provided for RBHA review quarterly and are used to update fiscal year-to-date tracking for all RBHAs. To better manage provider performance, NARBHA produces reports that describe quarterly and year-to-date performance for a detailed and informative analysis of change. Initially these reports are being utilized by NARBHA and its SAAs/TAAs to profile patterns of service delivery by aggregating data by units of services as well as cost. NARBHA has elected to apply criteria of provider utilization of two standard deviations above and below the mean in its statistical analysis to identify patterns of service delivery which, on the basis of probability theory, warrant further assessment and investigation to determine the cause of the variation and whether actual under- or over-utilization is occurring. Future benchmarks for expected performance will be established as NARBHA data are aggregated over time and statewide performance profiles are developed and made available to the RBHAs.

Case Management

Case management services are included in the covered service mapping model described above. Average units/dollars of case management within each SAA are compared to the NARBHA average across all SAAs. Performance outside of the normal expected range (e.g., outliers greater than 2 standard deviations above the mean or less than 2 standard deviations below the mean) is tracked and trended over time. Patterns of under- or over-utilization of case management services serve as the basis for further analysis and targeted performance improvement activities.

Medication/Pharmacy Utilization

Given the high-risk and increasingly high-cost aspects associated with medication utilization, NARBHA has implemented a polypharmacy reporting system to profile individual physician prescribing patterns across its region. This

tracking and reporting system currently focuses on excessive utilization of medications within the same interclass of medications (i.e., more than 3, 4, or 5), as well as per-member, per-month costs. Prescribing patterns are changing and reflect fewer incidences of potential over-utilization of medications. For example, during FY 2003-2004 the number of members on five or more medications decreased by 34%. Similarly, members on two or more atypical neuroleptics for more than 60 days decreased by 37.5%. One result of this tracking reporting system is that, despite rising medication prices, NARBHA medication costs per member per month actually decreased during FY 2003-2004 from $114.81 to $113.98—the first time in 10 years. Sharing these findings with prescribing physicians, as well as with provider agencies, has proven to be beneficial in increasing compliance with pharmacological best practices. An ongoing review of evidence-based research findings has been and will continue to be the basis of these efforts.

Out-of-Home/Out-of-Area Placements

Utilization of Out-of-Home/Out-of-Area services such as inpatient hospitals, sub-acute facilities, residential treatment centers, and the Arizona State Hospital represent the most acute levels of care. From a systems perspective, these placements are also the most costly services delivered for the benefit of members. If these services are not made available to members in need (under-utilization), or if this service is extended beyond what is needed by the member (over-utilization), both member quality of care and cost effectiveness suffer.

NARBHA tracks utilization of these higher levels of care on a regular and ongoing basis. Utilization standards and expectations are set by the NARBHA Plan and Design Committee based on historical utilization patterns and targeted improvements or changes in practice patterns, and provider performance is measured against those standards. The NARBHA PPC reviews utilization data by provider in comparison to utilization expectations on a quarterly basis. Utilization patterns and/or trends that exceed established upper and lower performance range expectations are referred for more intensive analysis and possible performance improvement requirements.

Utilization Management Record Review

NARBHA has delegated the functions of authorization and denial of services to the SAAs/TAAs, and requires these providers to make utilization decisions for these high-cost, high-intensity services in accordance with established criteria and policy requirements. NARBHA conducts a quarterly retrospective Utilization Management record review to ensure compliance with authorization requirements. One of the key components of this review is to identify potential under- or over-utilization of Out-of-Home/Out-of-Area services by reviewing the clinical record for appropriateness of admission, denial, and continued stay decisions. A sample of inpatient, residential treatment center, therapeutic group home, and sub-acute admissions is reviewed to ensure that utilization decisions have been made in accordance with defined criteria. Results are aggregated by provider agency and presented to the NARBHA PPC each quarter for review. Identified areas needing improvement are identified and addressed as needed.

Direct Feedback Received from Enrolled Members

An additional method for tracking utilization is direct feedback from members or families in the form of complaints or appeals. Complaints and appeals often are based on the perception of the enrolled member and family members that they are not receiving the frequency, intensity, or duration of services required to meet the member's needs. While all complaints are handled and followed up on an individual basis, aggregate analysis of complaints, appeals, and grievances also provides a basis for review of systemic performance patterns between and among the provider agencies. Aggregate data reports are reviewed by the NARBHA PPC. Potential patterns of under- and over-utilization are addressed and acted upon within the committee structure as needed.

NARBHA requires its Service Area Agencies and Tribal Area Agencies (SAAs/TAAs), key sub-geographic service area contractors, which provide community based, comprehensive behavioral health services, to notify members, agencies, and other involved parties of their right to appeal decisions made by the SAA/TAA, in accordance with ADHS/DBHS policy and timeframes for providing notice. Notices are provided to members or involved parties when a decision or action has been taken regarding their care. The notices describe the decision taken, the reason for the decision, the member's right to appeal the decision, and how to initiate the appeal process. Notices are written in language that is easily understood, and are provided to the member either in person or by certified mail. Interpreters are available for members needing language assistance.

Notices are also provided to members who are applying for, or who have been determined to have a serious mental illness, when decisions are made about their eligibility or care. These notices describe the decision made and the reasons for the decision, and inform the member about their right to appeal, how to initiate the appeal process, and the availability of assistance to them in filing an appeal and in obtaining an advocate. Notices are written in language easily understood and are delivered to the member either in person or by certified mail. Interpreters are utilized as necessary.

Information regarding Grievance and Appeals Notices is also contained in the NARBHA Member Handbook, which is provided to each NARBHA member. Beginning in FY 2004-2005, NARBHA's Member Handbook is available to members in Spanish in addition to English. This information is also on the NARBHA website.

Training

NARBHA provides training and training materials to be used by its SAAs/TAAs that describe when notices must be provided to members, how the notices must be distributed/provided to members, the type of notice required, how to complete the notice correctly, and the required timelines. New staff orientation and annual staff training, which is required for NARBHA and provider staff, includes information about Grievances and Appeals and the notice requirements. NARBHA also conducts training every six months with the SAAs/TAAs regarding notice requirements, time frames, and content of notices. In addition, NARBHA also has conducted a specialized training regarding SMI notice requirements for the SAAs/TAAs during FY 2003-2004. Ongoing technical assistance is available to each SAA/TAA for clarification of requirements.

NARBHA has also produced a one-page "Grievance and Appeal Notice Tip Sheet" which succinctly summarizes notice requirements and documentation. This has been distributed throughout the provider network and has contributed to increased compliance with requirements.

Monitoring and Improvement Initiatives

The NARBHA clinical record review staff include reviews of grievance and appeal notices as a part of the quarterly utilization management record review. Children who have received treatment in inpatient, residential treatment, and therapeutic group home settings, as well as adults receiving services in sub-acute facilities are sampled each quarter. 100% of denials of care are also reviewed. The review monitors for presence of required appeal notices, use of the correct notice form, and completeness and timeliness of notices. Review results are forwarded to ADHS/DBHS 45 days after the end of each quarter. The results are reviewed by the NARBHA Provider Performance Committee and referred for appropriate improvement efforts as warranted. Results are also forwarded to each SAA/TAA on a quarterly basis.

NARBHA providers, historically, have had difficulties in complying with notice, despite repeated corrective action efforts. During the past year, NARBHA has intensified improvement efforts with each of the agencies, including the following activities:

- On-site training and technical assistance by NARBHA staff, for clinical staff, at each of the provider sites
- Quarterly financial sanctions of provider agencies from July 2003 forward for each record not meeting compliance with notice requirements

These efforts have resulted in clearer understanding of complex notice requirements and in improved compliance at each provider. Additional efforts for improvement will include a requirement that provider agencies submit completed notices to NARBHA on a weekly basis for review for completeness. This increased oversight will allow for the provision of immediate feedback and technical assistance to the providers to improve their compliance. The expectation is that there will be continuous improvement in this area throughout the system.

NARBHA's member services and grievance and appeal staff respond to behavioral health recipients (members), family members, guardians, stakeholders, and all provider agencies regarding member rights and the processes for initiating complaints and filing appeals and grievances. NARBHA strives to facilitate resolutions of problems in a fair and timely manner, in accordance with ADHS/DBHS and federal requirements, and at the lowest possible level.

The grievance and appeal function, including complaint resolution; appeal and grievance investigation; conducting informal conferences; monitoring notice compliance; and training of Service Area Agencies/Tribal Area Agencies (SAAs/TAAs) regarding complaints, appeals, and grievances, is housed within the Quality Management Department at NARBHA. SAAs/TAAs are NARBHA's major comprehensive contractors which are responsible for sub-geographic areas and are the backbone of NARBHA's delivery system.

Tracking of complaints, appeals, and grievances is conducted by producing a quarterly report of aggregate data, which is categorized by problem type and provider agency. The quarterly report is reviewed by the NARBHA Provider Performance Committee and Risk Management Committee. Any systemic patterns or trends requiring further investigation or improvement initiatives are identified and addressed with the provider agencies.

Staff Functions, Responsibilities, Qualifications, Numbers

Grievance and Appeals Administrator (1)

- **Oversees NARBHA grievance, appeal, and complaint function.**
- Assures appropriate processing of grievances, appeals, and complaints in accordance with ADHS/DBHS timeframes and other contractual/legal requirements.
- Assigns grievances and appeals to appropriate NARBHA staff for investigation.
- Acts as designee of Chief Executive Officer to mediate Appeals-Informal Conferences.
- Coordinates investigations with NARBHA clinical/medical staff.
- Enters appeal and grievance data into ADHS/DBHS Office of Grievance and Appeals (OGA) database.
- Develops NARBHA and provider policies/procedures and other documents on grievance and appeals; oversees monitoring to see that policies are followed.
- Position requires law degree or certified paralegal in Arizona (in progress).
- Reports to Director of Quality Management.

Grievance/Appeal and Eligibility Specialist (1**)**

- Acts as primary investigator for seriously mentally ill (SMI) grievances. Conducts investigations and prepares investigative reports for review by Chief Executive Officer for final decision.
- Investigates provider claims appeals and prepares reports for Chief Executive Officer for final decision.
- Prepares aggregate complaint, grievance, and appeal tracking report and presents to NARBHA committees.
- Serves as NARBHA liaison to Northern Arizona Human Rights Committee.
- Staff has a Bachelors degree and experience in member services.
- Reports to Grievance and Appeals Administrator.

Member Service Representatives (2)

- Receive all member complaints; facilitate resolution in collaboration with NARBHA behavioral health professionals, as required. Maintain complaint-tracking database.
- Staff have a Bachelors degree and/or knowledge of and experience in behavioral health.
- Reports to Performance Improvement Manager.

Clinical Record Reviewers (1 reviewer, 1 reviewer/supervisor)

- Conduct quarterly record review monitoring of required grievance and appeal notices, prepare summary reports, and present findings to Provider Performance Committee.
- Develop training materials and conduct semi-annual trainings of SAAs/TAAs regarding notice requirements.
- Provide ongoing review, technical assistance, and training to SAAs/TAAs regarding notice requirements, as requested and required.
- Staff have Masters degrees, are licensed by the Arizona Board of Behavioral Health Examiners, and have clinical experience in behavioral health.

- Supervisor reports to Director of Quality Management; reviewer reports to supervisor.

NARBHA Licensed Behavioral Health Professional staff (including psychiatrists)

- Review all Title XIX/Title XXI submitted appeals and prepare Appeal Resolution reports.
- Review and make decisions regarding complaints received that involve clinical care issues.
- NARBHA utilizes several of its staff from Quality Management and other departments to review these items. Staff are selected based on their areas of competency and expertise and the nature of the appeal.

NARBHA complies with state and federal requirements for addressing and resolving complaints, appeals, and grievances as expeditiously and fairly as possible. Behavioral health recipients (members) are advised of their ability to file complaints, appeals, and grievances through the provision of appropriate notice to them at either the time of enrollment or at the time of a Service Area Agency/Tribal Area Agency (SAA/TAA) decision regarding their care. Additionally, members are advised of their right to file complaints, appeals, and grievances in the Member Handbook, which each member receives. Appeal and grievance rights also are posted at each of the SAA/TAA agency sites, as well as on the NARBHA website.

In handling complaints, appeals, and grievances, NARBHA strives to:

- Informally resolve disputes, complaints, and appeals as quickly and fairly as possible
- Maintain confidentiality and privacy
- Treat members, family members, and providers with respect and dignity
- Communicate with members, family members, and providers in such a way that they understand the process, taking into account cultural issues that may affect the treatment process
- Ensure that members and providers are kept informed of the current status of their complaint, appeal, or grievance
- Provide assistance in member's primary language, offering interpreter services as necessary

Complaints are handled by NARBHA through several processes. The process used is dependent upon the member's eligibility status and the type of decision, adverse action, or situation prompting the complaint. The various processes include informal complaint resolution, member appeals process, member grievance process, and provider claims disputes. The volume of complaints, grievances, and appeals in the NARBHA Geographic Service Area (GSA) includes approximately 200 complaints per year, and 50 total appeals, grievances, and provider claims disputes per year.

Complaint Process

A member complaint is the member's written or oral expression of dissatisfaction with their care, other than an action as defined by DBHS appeal policy and rules. (See actions listed below.) NARBHA has a centralized complaint resolution process in which complaints are received by Member Service Representatives. Complaints are addressed by obtaining information from both the member or complainant and the provider agency, and working in concert with the member to resolve issues at the lowest possible level. All complaints that involve clinical care are referred to NARBHA staff who are behavioral health professionals for the final NARBHA decision. NARBHA's internal standard for resolving complaints is not longer than 14 days. Urgent complaints, such as members out of medication or in immediate need, are resolved within 24 hours. Complaints are tracked through an internal tracking system and aggregate data are reviewed by the NARBHA Provider Performance Committee quarterly to identify any needed improvements or network sufficiency issues.

Appeal Process—Title XIX, Title XXI, Non-SMI Members

Members who are Title XIX or Title XXI enrolled may file an appeal with NARBHA to request review of an action made by one of NARBHA's SAAs/TAAs. The appeal must be filed within 60 days of the action or decision being appealed, and may involve the following SAA/TAA actions:

- the denial or limited authorization of a requested service, including the type or level of service
- the reduction, suspension, or termination of a previously authorized service
- the denial, in whole or part, of payment of a service
- the failure to provide services in a timely manner
- the failure to act within established timeframes for resolving an appeal or complaint and providing notice to affected parties
- the denial of the member's request to obtain services outside of the provider network

Appeals are filed directly with NARBHA grievance and appeals staff, and are acknowledged in writing within five days. NARBHA then obtains supporting clinical documentation from the appellant, as well as documentation from the SAA/TAA making the decision being appealed. All supporting information is forwarded to a NARBHA behavioral health professional, who develops the appeal resolution report and renders the NARBHA appeal decision. Any action by a provider agency physician, such as the denial of a prior authorized service, is referred to a NARBHA physician for the final NARBHA decision. The appeal decision is based upon the preponderance of evidence, and the burden of proof is on the appellant. The final NARBHA appeal resolution report is completed within 30 days and is forwarded to the appellant, as well as to the provider agency. The appellant has the opportunity to request a Fair Hearing if they disagree

with the NARBHA decision and wish to appeal. Fair Hearings are conducted by the Office of Administrative Hearings and provide an opportunity for the appellant and his or her representatives to present the case before an Administrative Law Judge for a decision.

Appeal Process for Persons with Serious Mental Illness

Persons with a serious mental illness (SMI), or their representatives, may file an appeal with NARBHA related to the following areas:

- decisions regarding the person's SMI eligibility determination
- sufficiency or appropriateness of their assessment
- the person's long-term view, service goals, objectives, or timelines stated in their treatment plan
- recommended services contained within their assessment or treatment plan
- actual services provided, as described in their treatment plan
- access to or prompt provision of services
- findings of the treatment team regarding the person's competency, capacity to make decisions, need for guardianship or other protective services, or need for special assistance
- denial of a request for a review of, the outcome of, a modification to, or failure to modify the treatment plan, or termination of a treatment plan
- application of the procedures and timeframes for developing the treatment plan
- implementation of the treatment plan
- the decision to provide service planning, including the provision of assessment or case management services to a person who is refusing services, or the decision not to provide such services to the person
- decisions regarding a person's fee assessment, or the denial of a request for a waiver of fees
- failure of NARBHA to act within the timeframes regarding an appeal

Persons with SMI, who are also Title XIX, may choose to have their appeal addressed either through the Title XIX appeal process or through an informal resolution process.

If the member chooses the informal resolution process, NARBHA holds a conference within seven days with the appellant, their representatives, and provider agency representatives. The appellant may appear either in person or telephonically. The informal conference is chaired by the NARBHA Chief Executive Officer, or designee, who attempts to mediate and resolve the issues in dispute to the appellant's satisfaction. If the appeal issues cannot be resolved at the informal conference level, the matter is referred for further appeal to ADHS/DBHS for a second informal conference. The appellant may waive the second informal conference and request an Administrative Hearing.

If the appeal issue relates to the person's eligibility for SMI services and is unable to be resolved at the NARBHA informal conference level, the appellant may request an Administrative Hearing.

Non SMI, Non-Title XIX, Non-Title XXI Appeals

Decisions made by SAAs/TAAs related to the determination of the need for Non-SMI, Non-Title XIX/XXI funded, covered behavioral health services may be appealed by members submitting an appeal to NARBHA. NARBHA requests supporting documentation from the appellant and the SAA/TAA making the decision. All information is reviewed and a NARBHA appeal decision is rendered within 30 days. The Appeal Resolution decision is forwarded to the appellant and SAA/TAA. The appellant may request an Administrative Hearing if they are dissatisfied with the final NARBHA decision.

Grievance Process

In accordance with A.A.C. R9-21, and in accordance with ADHS/DBHS policy, persons with SMI, as well as any other person, may file a grievance with the NARBHA Grievance and Appeals Administrator alleging potential rights violations for a person with SMI. They may also request a formal investigation related to situations alleged to exist within a provider agency that are dangerous, inhumane, or illegal for persons with SMI.

The NARBHA Grievance, Appeal, and Eligibility Specialist conducts an investigation that includes interviewing the grievant, other involved parties, and provider agency staff, as warranted. All relevant documentation is reviewed, including clinical record documentation as well as policies, procedures, and other documents. The investigative report is submitted to the NARBHA Chief Executive Officer, who renders a final NARBHA decision. The decision is issued

within 30 days, and either substantiates or does not substantiate that a rights violation occurred in accordance with the regulations.

If the grievant is not satisfied with the NARBHA decision, they have the right to request an Administrative Review of the investigation report and decision by ADHS/DBHS.

If the rights violation has been substantiated by NARBHA through the investigative process, NARBHA may require corrective action from the provider agency. Possible corrective action may include provider requirements for staff training, policy revision, or increased monitoring to ensure compliance with NARBHA or state requirements.

Provider Claims Disputes

A subcontracted provider agency may file a claims dispute directly with NARBHA for disputes involving:

- payment of a claim
- denial of a claim
- imposition of a sanction

Provider agencies are notified in writing of their right to file a claims dispute when a claim for payment is denied in whole or in part, or when the decision is made to impose a financial sanction. The claims dispute must be submitted by the provider within 12 months of the date of delivery of the service, within 12 months after the date of eligibility posting, or within 60 days after the date of the denial of timely claim submission, whichever is later.

NARBHA reviews all relevant supporting documentation regarding the dispute and issues a written, dated decision within 30 days, which includes a statement of the nature of the dispute, the NARBHA decision that approves or denies the claim for payment, and a statement of the reasons for the decision.

If the provider is not satisfied with the final NARBHA decision, they are advised of their right to request an Administrative Hearing conducted by the Office of Administrative Hearings in Phoenix. They will have the opportunity to present their case to an Administrative Law Judge, who will consider all facts presented and render a decision.

Tracking and Monitoring

All complaints received are tracked through NARBHA's complaint tracking system, which describes the complaint, member name and ID, Title XIX eligibility status, date the complaint was received, any identified communication need of the member, provider agency involved, length of time, and description of the resolution. Appeals, grievances, and provider claims disputes are tracked through the ADHS/DBHS Office of Grievance and Appeals database, in accordance with ADHS/DBHS requirements.

On a quarterly basis, a report is produced that integrates complaints, appeals, and grievance information by type of issue and provider agency involved. This tracking report is reviewed by NARBHA committees, which determine if quality improvement efforts are needed based upon the data, or if network sufficiency issues are identified that need to be addressed.

NARBHA has structured a multi-level process to ensure grievance and appeal rights are clearly communicated, and as a result, understood by behavioral health recipients (members).

Written Notice

The Member Handbook is the primary vehicle to communicate member rights information. It is distributed to each member at time of enrollment. It is also redistributed upon request to members, families and other community stakeholders. The Member Handbook is also available in Spanish, and an electronic copy is available on the NARBHA website.

Member rights are also posted in the common areas of each Service Area Agency/Tribal Area Agency (SAA/TAA). The SAAs/TAAs are NARBHA's major comprehensive providers responsible for sub-regional areas, and are the backbone of the NARBHA services delivery system.

Members are advised of their appeal rights at the time a decision is made about them. Written notice of their rights is either provided in person or by mail in accordance with ADHS/DBSH requirements. NARBHA requires the SAAs/TAAs to communicate the appeal notice information to members in "plain language". This includes no abbreviations or acronyms, and a clear description of the SAA/TAA decision to change or discontinue services.

Verbal Notice

Every effort is made to ensure that members understand their grievance and appeal rights. NARBHA has a 1-800 number which is distributed in the Member Handbook, available on the NARBHA website, and posted at the SAA/TAA waiting areas which allows members to contact NARBHA Member Services Representatives (MSRs). SAAs/TAAs and MSRs assist members in understanding their appeal rights when they are confused or have questions. If members are in need of interpreter services, including Native American languages, those services are available at SAAs/TAAs, as well as at NARBHA. Grievance and appeal forms are also available in Spanish. The right to an advocate is also explained to members who request or need assistance. NARBHA and providers work with families and advocate groups if necessary to assist members in understanding their rights.

Training

NARBHA provides semi-annual training of its SAA/TAA staff regarding how and when grievance and appeal rights need to be communicated to members. The training also includes handouts and materials which assist the SAAs/TAAs in understanding the requirements, and how to assist members with understanding their rights.

Monitoring

NARBHA monitors the appropriate dissemination of appeal notices through record review on a quarterly basis to ensure that members are receiving proper and complete notices of their right to appeal. If problems are identified, NARBHA provides additional training and technical assistance. Also, appropriate corrective action is required, and if it is not implemented and improvement achieved, financial sanctions are imposed.